Ohio | Department of Job and Family Services

Ohio medicaid QUALITY MONITOR

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Upcoming Studies

The Ohio Department of Job and Family Services (ODJFS) performs quality improvement activities which include evaluations that encompass quality of services delivered, access to care, regulatory impact on care, and recommended changes to delivery systems. As part of the ongoing efforts to help ensure the best use of Ohio fee-for-service Medicaid funds, *The Prior Authorization and Pre-certification Program Review* Project is currently being designed.

The purpose of *The Prior Authorization and Pre-certification Program Review* Project is to evaluate the current precertification and PA programs. The project will provide information that will enable ODJFS to make decisions as to what changes are needed and if so, what services, supplies, and procedures should require precertification or PA. The review will include the following:

- An analysis and evaluation of the use and costs of current lists of the 2233 codes for the supplies, services, and procedures that require PA and the 16 ICD-9 codes that crosswalk to 97 CPT codes that require Precertification.
- Clinical review of the current PA list and the current review indicators will be performed. This review will provided recommendations for indicator changes and reasons for the changes.
- An evaluation of the criteria/guidelines currently being used for PA/Pre-certification to ensure the criteria/guidelines support medical necessity and are understandable.
- An evaluation of the current services and procedures that require professional staff approval.
- An analysis and evaluation that will include the review for appropriate use of the J-code drugs that require prior authorization.
- An analysis and recommendations of whether prior authorization or pre-certification could be advantageous for certain services or procedures provided to targeted groups of the consumer population.
- An evaluation of the applicable Ohio Administrative Code rules and recommendations for changes.

This project will provide a thorough review of the current PA and pre-certification programs in order to maximize operational and clinical efficiencies. The information will assist ODJFS in providing updated flexible and cost-effective programs.

Admission Orders

By Anthony J. Beisler, MD, MBA, FACS, Medical Director, Permedion

Of the many utilization issues that ODJFS and Permedion encounter every day, one of the most consistent items concerns a basic element of charting and documentation: The Admission Order. While realizing that every facility is going to have a different methodology, everyone needs to be on the same page as to what constitutes a physician order for admission to inpatient status or observation level of care. So in an attempt to help clear up some of the confusion, let's review the basic tenets of the admission order:

- In accordance with Ohio Administrative Code (OAC) 5101:3-2-02, the order must be written by a physician in an area or on a sheet designated as Physician Orders. A valid physician order for inpatient admission is an order and not a progress note or a part of another document in the record.
- This order can be written by the attending physician or an Emergency Department physician.
- Standards of Care dictate that a complete admission order include: date, time, level of care, diagnosis, physician of record, and signature of the admitting physician.
- The word 'admission' is typically used to denote inpatient admission and inpatient hospital services.
- When there are conflicting orders with respect to patient status (observation vs. inpatient), the last order written is considered to be the valid one.
- In accordance with OAC 5101:3-2-02, an order to admit to inpatient status may NOT be written on the day of discharge; however, in instances when, on the day of admission, a patient dies or is transferred to another inpatient unit within the hospital, to another hospital, or to a state psychiatric facility admission on the day of discharge may be appropriate.
- Many hospitals are now going to a "Case Management Protocol" where the case management nurse specialists are assigning the status of the patient (Inpatient vs Observation) based upon clinical criteria according to national guidelines, such as Interqual and/or Milliman. These types of protocols are acceptable; however, the determination and subsequent order for admission, to either Observation status or inpatient status, MUST be countersigned, timed and dated by a physician with the concurrence of the attending physician.
- When coming from the ED, the ED records will often have a final disposition box where the ED physician will check off the final disposition such as discharged, admit, etc. This box being checked does not count as a valid admit order; however, if the ED physician writes in the ED Physician Orders section: "Admit to Inpatient – Dr. X – Dx: Acute Renal Failure—4West," that would qualify as a valid admit order.
- Electronic orders are acceptable. However, auto-populated date and time stamps at the top of the electronic orders are not as robust as a date and time stamp located directly next to the physician's electronic signature.

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- Telephone orders are acceptable as long as they are countersigned by the physician within 24 hours as per current national standards for documentation require.
- A single attending physician must be designated; one cannot admit a patient to a "group" practice.
- The order must indicate the level of care to which the patient is being admitted: Outpatient, Observation, or Inpatient. The complete wording of the level of care order is the best practice for establishing the correct level of care.

Below I've listed some of the most common examples of inappropriate orders which are seen during the course of medical review of claims.

- An order is written for the inpatient level of care when documentation does not establish the medical necessity for the inpatient level of service. Examples include: Patient has stabilized in Emergency Department (ED): Patient presents for planned minor procedure or treatment with known diagnoses; or Patient signs/symptoms do not warrant inpatient admission.
- An order is written to "admit as per case management protocol"; but the treating physician has not signed the level of care determination and/or the order assigning the status. Only the attending physician can determine if the patient meets criteria for inpatient admission vs. observation.
- There are confusing orders - such as, "Admit to Observation," "Admit for Observation" or "Hospitalize Patient on Inpatient ward for Observation." These orders do not clearly indicate an inpatient admission or observation status.
- An order is written to "send to 4West": Note that observation status can be provided anywhere in the hospital. This order does not clearly include the status of the patient.
- The admission order is written by personnel other than a physician and the attending physician does not sign the order. A physician must provide the admission order. Any verbal or telephone orders must be signed by the physician. If an order has not been signed within the time frame specified (24 hours), the order is not valid. The admission order cannot be signed during the course of an appeal after the case has been reviewed and denied for no valid order to admit. This action could be construed as fraudulently altering the medical record.
- The patient arrives at ED prior to midnight; orders for admission and/or inpatient services are not provided until after midnight. In this case, the inpatient admission date must be the same as the date of the order to admit, rather than the date the patient arrived at ED.
- The initial observation order was determined at a later point in time to have been inappropriate as the patient should have been admitted as an inpatient. An order is written for inpatient care on a different date than the initial assignment of observation status. Since orders cannot be retroactive, the admission date is the date the inpatient order is written, even if the patient could have been inpatient when the observation order was written. Note: When an admission order is written but the patient clinical status does not support the medical necessity for inpatient admission, the claim should not be billed as an inpatient claim.

As we move forward with cost consciousness in the health care reform environment, assigning the most appropriate level of care through a valid and complete admission or observation order to a given patient encounter episode will take on an ever increasingly important role.

CODING CORNER

Excisional Debridement

In this issue of the Coding Corner, we would like to discuss the correct coding and identification of the ICD-9 code 86.22, an excisional debridement (86.22) procedure and the ICD-9 code 86.28, a nonexcisional debridement.

The definition of excisional debridement is the surgical removal or cutting away of devitalized tissue, necrosis, or slough which can be performed in the operating room, emergency room, or at the patient's bedside. Excisional debridement may be performed by a nurse, therapist, physician assistant, or a physician.

Coding Clinic, Second Quarter 2004 indicates that the use of a sharp instrument does not always indicate that an excisional debridement was performed. Scraping away tissue is not considered an excisional debridement. Unless the documentation describes sharp debridement as a definite cutting away of tissue and not the minor removal of loose fragments with scissors or scraping away tissue with a sharp instrument, you need to assign ICD-9 code (86.28), a nonexcisional debridement of wound, infection, or burn. In performing excisional debridement (86.22), a scalpel is used to remove devitalized tissue and involves cutting outside or beyond the wound margin.

In regards to an excisional debridement (86.22), Coding Clinic, First Quarter 2008 indicates that clear and concise documentation is required in order to accurately report the procedure as an excisional debridement. All code assignments are based on provider documentation that supports the code that is assigned. It is critical that the hospitals work with their providers to ensure that documentation used to support the excisional debridement clearly describes the procedure performed. If the documentation is not clear or if there is any question about the procedure, the provider should be queried for clarification.

An example:

A 47-year-old diabetic male with a history of diabetic foot ulcers presented to the Emergency Room with left toe redness, swelling and blackness. The patient was admitted to the hospital with dry gangrene to the left foot and was placed on IV antibiotics. Blood sugars were monitored and the patient was treated with insulin. A bone scan revealed osteomyelitis and the blood cultures revealed no growth. The nursing staff provided wound care by performing wet-to-dry dressings, debridement, and whirlpool baths. The procedure was billed as an excisional debridement of skin (86.22) but the documentation does not support this code. The patient did receive a nonexcisional debridement of the skin (86.28), which is the appropriate code for this procedure.

If a diagnosis or procedure is questionable, always refer to the attending physician for clarification. Final coding is dependent upon provider documentation in the medical record.

Medical Director *dialogue*

By Anthony J. Beisler, MD, MBA, FACS
Medical Director, Permedion

Recently, there have been several questions regarding the use of reconstructive surgery after mastectomy for breast cancer. I thought I would provide a brief clinical review of Reconstruction after Mastectomy for breast cancer in this edition of Medical Director Dialogue.

Breast reconstruction was originally designed to reduce post-mastectomy complications and to establish symmetry between the surgical breast and the contralateral breast. Breast reconstruction after mastectomy has evolved over the last century to become an integral component of the standard of care for patients with breast cancer. Reconstruction can occur immediately after a mastectomy, or be delayed for weeks or years until a patient undergoes radiation, chemotherapy, or determines whether they want breast reconstruction.

The breast can be reconstructed in conjunction with mastectomy using breast implants, autologous tissue (i.e., flaps) or a combination of the two (e.g., latissimus/implant composite reconstructions). Reconstruction selection is based on an assessment of cancer treatment plans, patient body habitus, smoking history, co-morbidities and patient concerns. Current breast reconstruction procedures that are safe and effective and are well-established standards of care include: tissue/muscle reconstruction procedures (e.g., flaps), implantation of tissue expander, implantation of U.S. Food and Drug Administration (FDA)-approved internal breast prosthesis, areolar and nipple reconstruction, as well as areolar and nipple tattooing.

Currently, coverage for breast reconstruction following mastectomy or lumpectomy is governed by federal and/or state mandates. These laws and coverage determinations establish reconstructive breast surgery to a normal breast form (size, shape and appearance) as medically necessary. Procedures are also performed on the non-diseased, unaffected, contralateral breast, in order to produce a symmetrical appearance and are also considered medically necessary.

For further information, see the following references:

- American Cancer Society (ACS): Breast reconstruction after mastectomy. Updated September 1, 2009. Available at URL address: http://www.cancer.org
- Medicare National Coverage Determinations Manual, Chapter 1, Part 2 (Section 140.2) Coverage Determinations, *(Rev. 136, 11-02-11),* Accessed at: https://www.cms.gov/manuals/downloads/ncd103c1_Part2.pdf
- National Comprehensive Cancer Network (NCCN). NCCN® practice guidelines in oncology. Breast Cancer. V.2.2010. Available at URL address: http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

Prior Authorization vs. Pre-Certification for Hospitals

The Ohio Administrative Code (OAC) requires hospitals to obtain two different types of authorization for specific Medicaid services. The Prior Authorization (PA) requirement is for procedures that are normally considered non-covered, and must be reviewed for medical necessity. (Except transplants, these are covered but still require prior authorization.) The Pre-certification requirement is for all psychiatric admissions, and for covered surgical procedures that are normally performed in an outpatient setting but requesting approval to perform in an inpatient setting. **Prior authorization and Pre-certification are not required when Medicare is the primary payer.**

Prior Authorization

There is not a published list of services that require prior authorization for inpatient procedures, but the OAC rule 5101:3-2-03, *Conditions and Limitations*, describes the types of services that would require prior authorization. Anything that requires prior authorization in the outpatient hospital setting has a PA indicator next to the CPT code on the applicable appendix in OAC Rule 5101:3-2-21, *Policies for Outpatient Hospital Services*. Prior authorization will be granted if a service that is typically not covered is proven to be medically necessary for a consumer.

Procedures that require prior authorization are never exempt from prior authorization, so a retrospective review for PA can be requested. A claim submitted with a procedure requiring PA will never pay without an authorization.

Pre-Certification

There are two types of services that require pre-certification for inpatient admissions. The first is for surgical procedures that require pre-certification. These surgical procedures are established and published by the Ohio Department of Job and Family Service. The second is for psychiatric admissions. If the admitting ICD-9 diagnosis code falls between the range of 290.00 - 316.00, the admission requires pre-certification. OAC rule 5101:3-2-40, *Pre-certification Review*, further defines and describes the requirements for pre-certification.

Surgical procedures requiring pre-certification must be obtained prior to the inpatient admission unless it meets one of the exemptions listed in Paragraph C of OAC rule 5101:-3-2-40, *Pre-certification Review*. If the admission does NOT meet one of these requirements,

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the pre-certification cannot be retrospectively issued. The claim cannot be billed as inpatient. If the surgical admission meets the exemption policy listed in Paragraph C of the rule, you can submit the claim using the 'AN' Condition Code to indicate they were exempt from pre-certification. (The 'AN' Condition Code cannot be used with psychiatric admissions or procedures requiring prior authorization.)

Psychiatric admissions requiring pre-certification must be obtained prior to the admission or within the next business day of the admission. If Medicaid eligibility was pending at the time of psychiatric admission, **or** if Medicaid eligibility was granted retrospectively, the hospital will need to request a retrospective pre-certification number. The hospital should provide proof or reasonable assurance that eligibility was checked at the time of admission, so that their request may be processed in accordance with OAC guidelines.

If a person is admitted for medical reasons but after admission and medical evaluation, it's determined the reason for the care was psychiatric in nature, pre-certification is not required. The admitting diagnosis codes on these claims will indicate an acute medical condition.

The list of procedures requiring pre-certification can be found on Permedion's website at http://www.hmspermedion.com/OhioMedicaid.htm

To locate the Ohio Administrative Code rules discussed in this article, please visit the Ohio Department of Job and Family Services e-Manuals web page for the department's rules, manuals, and handbooks. The URL is http://emanuals.odjfs.state.oh.us/emanuals/

Providers may view documents online by:

(1) Select "Ohio Health Plans – Provider."

(2) Select "Hospital Handbook"; and

(3) Selecting the desired item (Hospital Services Ohio Administrative Code)

- All prior authorizations and surgical pre-certifications must be obtained through the MITS Prior Authorization Web-Portal.
- Psychiatric pre-certifications must be obtained through Health Care Excel:

  Contract Director
  Ohio URIP Program
  Health Care Excel, Incorporated
  1-800-580-1937

  Effective 7/1/12, all psychiatric pre-certifications must be obtained through the MITS Prior Authorization Web Portal.
- Transplant prior authorizations must be obtained through the appropriate consortium:

  Ohio Solid Organ Transplantation Consortium, 1-614-504-5705
  Ohio Hematopoietic Stem Cell Transplant Consortium, 1-440-585-0759

Helpful Hints for the Prior Authorization Web-Portal:

1. When requesting the authorization, be sure the "Servicing Provider" field in the web-portal is the hospital's provider number.
2. When requesting prior authorization for more than one procedure code, list each additional procedure code on its own detail line within the prior authorization request.
3. If the service requested will be billed with multiple units (i.e. 4 units = 1 treatment), you must indicate the number of units that will be billed. Associated claims will be limited to the number of approved units on the prior authorization.
4. If the 'AN' condition code is submitted on a claim when a procedure doesn't require pre-certification, or if it's submitted on a claim with a procedure that requires prior authorization, the claim will deny. The 'AN' condition code can only be used when a procedure is exempt from pre-certification as defined in paragraph C of OAC 5101:3-2-40.

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